NC DIVISION OF MH/DD/SAS
2007 CAP-MR/DD Medicaid Waiver Audit

AUDITOR INSTRUCTIONS

Protocol for selecting a sample: All events for the Medicaid Waiver Services audit will be drawn from **paid claims** dates from **March. 1, 2007 – July 31, 2007**. Ten (10) primary and five (5) backup service dates per CAP-MR/DD Provider will make up the sample, for a total of 15 possible service event dates.

NOTES:

- If the provider found documentation/billing errors and made a pay back to Medicaid for a service event audited prior to the date the list of records was sent to them, do not include the event in the audit. Replace it with an alternate. Start with control #11 and use the alternates in order. Note this in the comments section of the audit form and attach a copy of documentation confirming the date and amount of the payback for the event excluded.
- Reviewer must complete all sections of the audit sheet and will be responsible for acquiring all needed information.
- Place color post-it flag on all "NOT MET" events; arrange in control number order and give to Team Leader for final processing. **Team Leader needs to review the audit tools before the provider leaves!**

Q1 – Service Authorization

The service authorization goes through the Value Options network. Effective September 1, 06.Services are the discreet waiver services that include Day Supports, Home & Community Supports, Personal Care ,Residential Supports, Respite and Supported Employment..

- Must be in place on or before the date of service.
- **1a - If Not Met, enter dates FROM: the first date the service order is not valid (No further back than 7/1/06) TO: is the date a valid service order went into effect, or the date of the audit.**

Q2 – Provider Enrollment

- Request to see the letter from Debra Hunt's office at DMA that indicates the provider agency is enrolled in Medicaid **to deliver the specific service for which they have billed**. The service must be listed in the letter to rate the question "1/Met".

Q3 – Service Plan is Current

- Initial plan and annual CNR must be signed by the legally responsible person and the case manager (if cm is not a QP then a QP must also sign). Service Order is the POC signed by the appropriate professional. i.e. Targeted Case Manager.Must be in place on or before the date of service.
- Plans must be completed annually during the consumer's birthday month, effective the first day of the next month.
- Plans that have been reviewed and/or revised must have signatures of those listed above. Target dates must be reviewed and revised if the outcome / goal / objective is continued after the projected date of accomplishment.

- **3a - If Not Met, enter dates: FROM: is the first date the service plan is not valid (No further back than 7/1/06 TO: is the date a valid service plan went into effect, or the date of the audit.**

Q4 – Service Plan Identifies Service Billed

- Specific service to be billed **must be listed** in the Plan of Care. The cost summary is **not** enough
- **4a - If Not Met, enter dates when the service plan did not identify the service billed as in 3a above.**

Q5 – Documentation is Initialed and Signed

- The direct service provider is to initial for each day he/she provides service to the individual.
- Each direct service provider must fill out info on the back – print name, full signature, including position (paraprofessionals) or credentials (professionals) and initials. *[The position/credentials do not have to be handwritten, but they have to be there.]*
- The initials on the back of the form need to match with those on the front to determine that the provider "signed" the service documentation.

Q6 – Service Note/Log reflects Purpose of Contact, Staff Intervention, Assessment of Progress toward Goals

- Note format must comply with Service Records Manual and CAP-MR/DD Manual, including any revisions.
- **Grids used to document Day Habilitation, Residential Supports, Home and Community Supports and Supported Employment must separately document the intervention and assessment of progress toward goals.**
- There must be a separate key for intervention and for assessment of progress.
- Other CAP Services follow the Services Records Manual and 2005 CAP manual.

Q7 – Service Note/Log Relates to Goals

- Service note/log documentation corresponds to an outcome on the Plan of Care. Outcomes may be re-written verbatim, paraphrased or represented by #.
- The outcome is not expired or overdue for review.

Q8 – Specific Service Definition Requirements are Met

See attached list of special requirements

Q9 – Units Billed match Duration of Service

- Duration of service for periodic and day/night services must be documented.
- Residential Supports (Daily service rate) levels I-IV (Appendix M) have a duration of "1", but the "1" does not have to be documented.

Q10 – Documentation Reflects Treatment for the Duration of Service

- Determine that the documentation provided for a specific date of service adequately represents the number of units billed – did the activity reasonably take place in the time indicated?

Q11 - Qualifications:

Request documentation that indicates all of the following:

- Providers of the following services must be a QP, AP or staff with at least a HS diploma or GED supervised by a Q:
    - **Developmental Day** *(if child served is age 0-3, staff must meet Early Childhood Intervention competencies).*
    - **Day Habilitation**
    - **Supported Employment**
    - **Residential Supports**
    - **Home and Community Supports**
    - **Crisis Stabilization**
- All staff must be deemed qualified to provide the service on or before the date of service. (If qualified later, check for provisional qualifying if allowed for professionals.)
- Paraprofessional and professional staff must meet the educational requirements per individual CAP-MR/DD services in Appendix L, and in State rule.
- In addition to the above, any additional requirement of the provider policy and procedures on qualifications must be met for either professionals or paraprofessionals.
- **Enhanced Services**: any special training required by the POC must be followed.
- If the Service Note/Log is not signed or missing, staff qualification/core competencies are rated "7".

Q12 – Supervision Plans:

- Agency must have policy on supervision – ask to review it.
- Supervision plans for paraprofessionals and associate professionals must be in place **and implemented**.
- **12a** – Enter "1/0" = "Met/Not Met" if the supervision plan is or is not in place.
- **12b** – Enter "1/0" = "Met/Not Met" if the supervision plan is in place but not implemented.
- **12c -** If the supervision plan is not implemented as written, enter the dates of non-compliance in 12c, for example:
    - Supervision plan calls for 1/month supervision. Event date is March 12. Enter "FROM: March 1 TO: March 31, 2006" in 12c.
    - Supervision plan calls for 1/week supervision. Event date is March 12. Ask what the work week is (i.e., Monday-Sunday). Look up corresponding dates for the week and enter in 12c, i.e. "March 1 – 7, 2006).
    - Supervision plans must comply with service requirements if applicable.

Q13 – Criminal Record Check:

- Refer to Appendix L in CAP Manual. The only services we will audit that **do not require the criminal record check:**
    - Institutional Respite
    - Adult Day Health
- **13a** - **If Q13 is Not Met, enter dates FROM: the first date there was no Criminal Record check (no further back than 7/1/06) TO: is the date the Criminal Record check was done, or the date of the audit.**

Q14 – Health Care Personnel Registry Check:

- Refer to Appendix L in CAP Manual. The only services we will audit that **do not require the Health Care Personnel Registry check are:**
  - Institutional Respite
  - Adult Day Health
- There may be **no substantiated finding of abuse or neglect** listed on the NC Health Care Personnel Registry

- **14a - If Q14 is Not Met**, **enter dates FROM: the first date there was no Health Care Personnel Registry check (no further back than 7/1/06) TO: is the date the Health Care Personnel Registry check was done, or the date of the audit.**

Comment Section:

- Comment on/clarify any "not met" elements above.
- Note and make recommendations regarding other service plan or service note/log deficiencies that are out of compliance with State rules other than the CAP-MR/DD Medicaid required criteria above.
- Identify examples of excellence.
- Attach copies of documentation for "not met" and commendable elements.
- If and alternate/back-up control sheets are used, note this in the comments section of the audit form and attach a copy of documentation confirming the date and amount of the payback for the event excluded.